

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155484	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/01/2014
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 04/01/14</p> <p>Facility Number: 000564 Provider Number: 155484 AIM Number: 100285610</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Kindred Transitional Care And Rehab-Southwood was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility consisting of the original construction and a later addition identified as Reflections and the southwest section of 2B were constructed prior to March 2003. Both areas were determined to be of Type V (000)</p>	K010000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>construction and were fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in spaces open to the corridors. The Reflections and southwest section of 2B have hard wired smoke detectors in resident rooms. All other resident rooms were equipped with battery powered smoke detectors. The facility has a capacity of 149 and had a census of 123 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. Areas providing facility services were sprinklered except a detached garage and two wooden sheds used for maintenance and equipment supply storage.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/07/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			
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K010044 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 6 fire door sets was arranged to automatically close and latch. LSC 7.2.4.3.8 requires fire barrier doors to be self closing or automatic closing in accordance with 7.2.1.8. NFPA 80, the Standard for Fire Doors and Fire Windows at 2-4.1.4 requires all closing mechanisms shall be adjusted to overcome the resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice affects visitors, staff and 10 or more residents on the 500 hall and the adjacent smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 04/01/14 at 10:30 a.m., the 500 hall fire door set was tested twice manually with the maintenance director. One door in the fire door set failed to latch when the doors were released to close. The doors failed to latch again at 11:00 a.m. when the fire alarm was activated. The maintenance director acknowledged at the time of observations, the doors were not closing and latching. He said he felt a draft in the hall which interfered with</p>	K010044	I am respectfully requesting a desk review. There were not any residents or staff found to have been affected by this practice. In order for residents and staff not to be affected by this practice the fire door set on 500 hall was manually adjusted on April 1, 2014 in order to maintain the fire barrier doors to be self closing or automatic closings. All Fire barrier doors will be checked weekly for 3 months, monthly for 3 months then quarterly on-going by the Director of Maintenance to ensure that the deficient practice does not occur. Director of maintenance is responsible to validate proper working condition of fire barriers. Director of Maintenance will report validation monthly at facility QA meeting.	04/02/2014			

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	closing. 3.1-19(b)			